Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on December 29, 2003.

I. DISPUTE

Whether there should be reimbursement for CPT code 99212 rendered on 8/25/03, CPT codes 99212, 97113 rendered on 10/6/03, CPT codes 99212, 97113 rendered on 10/7/03 and CPT codes 99215-25 and 97113 rendered on 10/9/03.

II. RATIONALE

Review of the requestor's request for reconsideration letter dated November 18, 2003 states in part, "...I have again attached the documentation to this reconsideration for the 10 minute off. visit on 08-25-03. We believe that we have complied with TWCC MFG and that this should be paid per the attached documentation. …"

Review of the requestor's request for reconsideration letter dated November 11, 2003 states in part, "...See the attached TWCC 53, which approves the change of treating doctor from ___, D.C., to ___, D.C. I did speak to ___ at TWCC in Lufkin regarding our claims Being [sic] denied for L and she said that this was resolved with the change to ___, D.C., approved as the treating doctor. Remit payment for our services as this has been approved with TWCC.

It is time for the carrier to re-review its decision based upon the information this facility has presented. The carrier must force itself to ask if a simple mistake has been made and perhaps it is time to correct it, before the possible penalties must be requested. …"

Review of the respondent's position statement dated January 26, 2004 states in part, "…an exhaustive period of aquatic therapy has not proven to be medically necessary, and its benefits have not been documented as being of medical benefit to the claimant. For medical necessity to be established there must be an expectation of recovery or improvement within a reasonable and generally predictable time frame. In addition, the type, frequency and duration of services must be reasonable and consistent with the standards of practice in the medical community. When the medical documentation does not reflect a benefit from the treatment regimen, then the regimen should be changed or modified to achieve a medical benefit to the patient. When any treatment duration and/or number of visits exceed the standards of care, there should be documented factors identifying the need for deviation form [sic] those standards. Evidence of objective functional improvement is essential to establish reasonableness and necessity of care. …"

According to the TWCC Rule 133.307 (j)(2), the response shall address only those denial reasons presented to the requestor prior to the date the request for medical dispute resolution was filed with the division and the other party. Response shall not address new or additional denial reasons or defense after the filing of an request. Any new denial reasons or defenses raised shall not be considered in the review. Therefore, the disputed charges will be reviewed according to the carrier's EOB denials.

Review of the carrier's EOB with a post date of 11/4/03 revealed that the carrier has denied CPT codes 99212, 97113, 99215-25 rendered on 10/6/03 thru 10/9/03 as "L-242-Not Treating Doctor". Review of the Employee's Request to Change Treating Doctors revealed that the commission approved the request on 9/5/03 to reflect Dr.___, D.C., and the new treating doctor. According to the request, Dr. ___ is no longer accepting worker's compensation patients. Therefore the disputed charges denied by the carrier as "L" are recommended for reimbursement according to the Medicare Fee Schedule.

Review of the carrier's EOB with the carrier pay date of 10/10/03 revealed that the carrier has denied CPT code 99212 as "N-Not appropriately documented". Review of the requestor's S.O.A.P. supports the documentation criteria set forth by the Medical Fee Guideline and the CPT code descriptor. Therefore, the requestor is entitled to reimbursement according to the Medicare Fee Schedule.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	Medicare Fee Schedule x 125% = MAR$
8/25/03	99212	$41.91	$0.00	N	$33.53 x 125% = MAR - $41.91
10/6/03	99212	$41.91	$0.00	L	$33.53 x 125% = MAR - $41.91
10/6/03	97113 x 6 units	$312.00	$0.00	L	$27.70 x 125% = $34.63 x 6 units = MAR $207.78
10/7/03	99212	$41.91	$0.00	L	$33.53 x 125% = MAR - $41.91
10/7/03	97113	$312.10	$0.00	L	$27.70 x 125% = $34.63 x 6 units = MAR $207.78
10/9/03	99215-25	$100.00	$0.00	L	$108.74 x 125% = MAR - $135.93, however the requestor billed the amount of $100.00 and is therefore entitled to the lesser of the two billed. Reimbursement is recommended in the amount of $100.00.
10/9/03	97113	$312.00	$0.00	L	$27.70 x 125% = $34.63 x 6 units = MAR $207.78
TOTAL		$1,161.80	$0.00		The requestor is entitled to reimbursement in the amount of $849.07.

III. DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor is entitled to reimbursement for CPT code 99212, 97113, and 99215-25 in the amount of **$849.07.** Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the Respondent to remit **$849.07** plus all accrued interest due at the time of payment to the Requestor within 20-days receipt of this Order.

The above Findings, Decision and Order are hereby issued this 5th day of April 2004.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo